Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TWELVE OAKS MEDICAL CENTER

Respondent Name
STATE FARM GENERAL INSURANCE CO

MFDR Tracking Number
M4-06-7090-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 13, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000.00 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401(c)(6)(A)(v). Calculation of stop-loss reimbursement is $297,631.88 (total billed) X SLRF (75%) $74,399.96 = $231,199.87 less 8% ($18,495.99) per FIRST HEALTH contract = $212,703.88 total allowable."

Requestor's Supplemental Position Summary Dated June 22, 2007: "TOMC has also requested that Francis, Orr & Totusek, L.L.P. and the undersigned by substituted in as counsel in place of Daniel T. Hollaway and the firm of Hollaway & Gumbert, P.C. on this matter."

Amount in Dispute: $127,460.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated August 2, 2006: "State Farm Insurance Company hereby files a motion for dismissal of this docketed medical dispute due to currently unresolved compensability issues."

Response Submitted By: John Fowler

Respondent's Position Summary Dated August 29, 2012: "The carrier is requested to provide a copy of the contract between State Farm General Insurance Company and the informal/voluntary network and a copy of the contract between the informal/voluntary network and Twelve Oaks Medical Center. In addition, the carrier is requested to provide documentation to support that Twelve Oaks Medical Center was notified pursuant to former DWC Rule 133.4. Rule 133.4 is inapplicable to this case, as that rule was not adopted until July 27, 2008, well after the dates of service in this case…Please further note that although the First Health Network agreement was applicable to the charges in dispute in this case, State Farm General Insurance Company did not make any PPO reductions because the carrier paid based on an on-site audit."

Response Submitted By: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 15, 2005 through August 3, 2005	Inpatient Hospital Services	$127,460.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.304 requires the insurance carrier to sufficiently explain on the explanation of benefits the reason for the denial and/or reduction.
3. 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital for the date of admission in dispute.
4. 28 Texas Administrative Code §134.1, effective May 16, 2002 sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
5. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services."
6. The services in dispute were reduced / denied by the respondent with the following reason codes:

   Explanation of Benefits
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Does a compensability, extent, and/or liability issue exist in this dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the Division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as

described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed

1. The respondent states in the original position summary that "**State Farm Insurance Company hereby files a motion for dismissal of this docketed medical dispute due to currently unresolved compensability issues**."

   Per 28 Texas Administrative Code §133.304(c) states "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. The insurance carrier shall maintain documentation of the date it sent the explanation of benefits, and shall either maintain a copy of the explanation of benefits or be able to electronically reproduce it. The explanation of benefits may be printed on the insurance carrier's letterhead but must include all language required by the Commission." A review of the submitted explanation of benefits finds that the insurance carrier did not raise compensability, extent, and/or liability issues.

   28 Texas Administrative Code §133.307(j)(2) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review." The Division finds that the respondent has raised new or additional denial reasons or defenses after the filing of a request. Therefore, the issue of compensability, extent, and/or liability issues will not be addressed any further in this decision.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $297,631.88. The Division concludes that the total audited charges exceed $40,000.

3. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services" and further states that "…independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor in its position statement states that "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000.00 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401(c)(6)(A)(v). Calculation of stop-loss reimbursement is $297,631.88 (total billed) X SLRF (75%) $74,399.96 = $231,199.87 less 8% ($18,495.99) per FIRST HEALTH contract = $212,703.88 total allowable.**"** This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The requestor's position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar surgical services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).

5. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:

(i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
(ii) the hospital's usual and customary charges; and
(iii) reimbursement as set out in section (c) of this section for that admission

In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation "Charges exceed your contracted/legislated fee arrangement." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier State Farm General Insurance Co. and Twelve Oaks Medical Center prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b)(2)(A)(i) does not apply.

In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal $297,631.88.

In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were ICU; therefore the standard per diem amount of $1,560.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." The length of stay was 19 days. The ICU per diem rate of $1,560.00 multiplied by the length of stay of 19 days results in an allowable amount of $29,640.00.

- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Code	Itemized Statement Description	UNITS	Cost Per Unit	Cost + 10%
0278	Pin Steinman II	3	$42.00	$138.60
0278	CRLK LMBR 10MM	3	$4,320.00	$14,256.00
0278	CRLK LMBR 11MM	1	$4,320.00	$4,752.00
0278	Crosslink MDM	1	$945.36	$1,039.90
0278	Crosslink SMLL	1	$945.36	$1,039.90
0278	CTRCL CNCLS CR	1	$350.00	$382.00
0278	DURA MATER SML	1	No support for cost/invoice	$0.00
0278	DURAGEN	1	$593.00	$652.30
0278	Locking Cap	8	$169.92	$1,495.30
0278	TISSEAL	1	No support for cost/invoice	$0.00
0278	10cc Putty	1	$1,082.00	$1,190.20
0278	110 mm Hex Rod	1	$238.32	$262.15
0278	6.75X45 Screw	1	$799.92	$879.91
0278	6.75X50 Screw	1	$799.92	$879.91
0278	7.75X45 Screw	1	$799.92	$879.91
0278	Wax Bone 2.5gm	1	No support for cost/invoice	$0.00
0278	BN Grft BMP LG	1	$4,990.00	$5,489.00
TOTAL ALLOWABLE $33,340.08				

- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (ii) Computerized Axial Tomography (CAT scans) (revenue codes 350-352,359)." A review of the submitted hospital bill finds that the requestor billed revenue code 350 at $2,908.50 CT Head/BR/WO; $1,684.75 for CT Head/BR/WO/W; and $1,710.00 CT SP Lumb W/O. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 350 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (i) Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)." A review of the submitted hospital bill finds that the requestor billed $3,561.00 for revenue code 610-BR/HD W/WO CM. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 610 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $1,344.00 for revenue code 81-Packed Red Cells. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 381 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $329.00/unit for Vancomycin 1gm, $439.25/unit for Amiodarone 150mg, $258.00/unit for Vasotec 2ml. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, additional reimbursement for these items cannot be recommended.

The total reimbursement set out in the applicable portions of (c) results in $29,640.00 + $33,340.08, for a total of $62,980.08.

Reimbursement for the services in dispute is therefore determined by the lesser of:

§134.401(b)(2)(A)	Finding
(i)	Not Applicable
(ii)	$297,631.88
(iii)	$62,980.08

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c)(4) represents the lesser of the three considerations. The respondent issued payment in the amount of $85,243.53. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date

Signature	Health Care Business Management Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.